



**California State Board of Pharmacy**  
1625 North Market Blvd., N219, Sacramento, CA 95834  
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www.pharmacy.ca.gov

STATE AND CONSUMER SERVICES AGENCY  
DEPARTMENT OF CONSUMER AFFAIRS  
ARNOLD SCHWARZENEGGER, GOVERNOR

## **NOTICE OF MEETING and AGENDA Communication and Public Education Committee**

**Date: October 2, 2008**  
**Time: 10:30 a.m. – 1:30 p.m.**

**Contact: Virginia Herold**  
**(916) 574-7911**

**Place: Department of Consumer Affairs**  
**1625 N. Market Blvd, El Dorado Room (Suite N-220)**  
**Sacramento, CA 95834**

This committee meeting is open to the public and will be held in a barrier-free facility in accordance with the Americans with Disabilities Act. Any person with a disability who requires a disability-related modification or accommodation in order to participate in the public meeting may make a request for such modification or accommodation by contacting Michelle Leech (916) 574-7912, at least five working days before the meeting.

Opportunities are provided for public comment on each agenda item. A quorum of the board may be present at committee meetings. Board members who are not on the committee may observe, but may not participate as a Committee member or vote.

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***Note: Pharmacists and pharmacy technicians who attend the full committee meeting can be awarded two hours of CE, in accordance with the board's CE policy. A maximum of four CE hours can be earned each year by attending the meetings of two different board committees.***

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### **Call to Order**

**10:30 a.m.**

1. Ongoing Discussion of Medication Errors and How to Prevent Them
2. Discussion of Comments Submitted in Response to Proposed Rule Changes to 45 CFR Part 88, Ensuring That Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law (Conscience Clauses), RIN 0991-AB48
3. Discussion Regarding Action to Implement SB 472, Patient-Centered Medication Container Labels
  - Report of Patient Surveys Undertaken
  - Discussion of Presentations and Agenda Planned for November 20, 2008 Forum
4. Update and Discussion Regarding the Consumer Fact Sheet Series with California Schools of Pharmacy Interns
5. Development of New Consumer Brochures by the Board
6. Request from PPSI to Develop Consumer Brochures
7. Update on *The Script*
8. Update on Public Outreach Activities
9. Public Comment for Items Not on the Agenda\*

### **Adjournment**

**1:30 p.m.**

***\*Note: The committee may not discuss or take action on any matter raised during this public comment section that is not included on this agenda, except to decide to place the matter on the agenda of a future meeting. [Government Code Sections 11125, 11125.7(a).]***

***Meeting materials will be available from the board's Web site by September 29, 2008.***



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STATE AND CONSUMERS AFFAIRS AGENCY  
DEPARTMENT OF CONSUMER AFFAIRS  
ARNOLD SCHWARZENEGGER, GOVERNOR

**Date: September 27, 2008**

**To: Communication and Public Education Committee**

**Subject: Medication Errors Investigated by the Board of Pharmacy**

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At the July 2008 Board Meeting, the board held a forum on medication errors. Michael Cohen of the Institute for Safe Medication Practices, John Keats of California Patient Safety Action Coalition (CAPSAC), and Bob LeWinter of the California Department of Public Health provided presentations on activities underway to prevent pharmacies from making or repeating medication errors. A discussion also involved another discussion of the findings of the 2006 SCR 49 Medication Errors Task Force report.

At this meeting, Executive Officer Herold provided a presentation of the medication errors cited and fined by the Board of Pharmacy during 2007-08. There were 402 medication errors reported to the board during this period, and 600 medication error cases closed during the period. Of these cases 94 percent were substantiated as errors.

During the discussion during the board meeting and then later during the Communication and Public Education Committee Meeting (held in conjunction with the board meeting), Executive Officer Herold suggested including information in the Board's Newsletter or in a separate issue on some of the medication errors investigated by the board.

The following pages provide the information that will be converted into this medication error supplement to the newsletter.

The committee may wish to discuss how it wishes to proceed with respect to educational activities to the profession and consumers about medication errors. Both CPhA and the Institute for Safe Medication Practices have expressed interest in working with us in this area.

One area is the emerging emphasis on using TALL MAN Letters in prescriptions to prevent look-alike drug names from being confused. Attached are several articles from the Institute for Safe Medication Practices, and one expressing the National Association of Boards of Pharmacy policy on this subject.

Also attached are two additional articles on medication errors and ways to prevent them by pharmacies.

## ② MEDICATION ERROR DATA

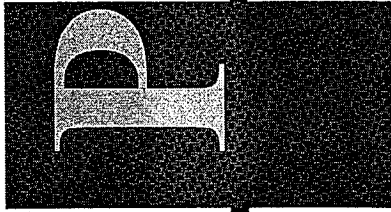
All pharmacy settings July 1, 2007 – July 1, 2008

Common Look-alike Sound-alike Errors	Prescribed	Dispensed
	Abilify	Adderall XR
	Augmentin	Amoxicillin
	Darvocet N	Darvon N
	Desipramine	Disopyramide
	Felodipine	Feldene
	Hydralazine	Hydroxyzine
	Lipitor	Lisinopril
	Lovastatin	Loratadine
	Lumigan	Lotemax
	Naproxen	Naproen
	Metolazone	Metoclopramide
	Risperal	Requip
	Parnate	Paxil
	Pepcid	Prilosec
	Pravachol	Prevacid
	Simvastatin	Sertraline
	Trazodone	Tramadol
	Zyrtec	Zantac
	Zyrtec	Zyprexa
	Zetia	Zyrtec

## ② PRESCRIPTION ERRORS DATA

All pharmacy settings July 1, 2007 – June 30, 2008

Medication Error Category	Number	Percent of Total Citations
Wrong Drug	174	39%
Wrong Strength	72	16%
Wrong Instructions	77	17%
Wrong Patient	46	11%
Wrong Medication Quality	24	5%
Other Labeling Error	25	6%
Compounding/Preparation Error	11	2%
Refill Errors (frequency, timeliness)	1	<1%
Total # Citations for errors (may have more than one category listed)	445	



## PRESCRIPTION ERROR CASES

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### \$500 Fine

- # **Case 1:** An 8 month-old child was given a prescription for Novahistine DH (Phenylhist DH), a codeine-containing product. The Pharmacist incorrectly typed the directions on the prescription label as give 1 and 1/2 teaspoonfuls by mouth every 6 hours instead of the prescribed direction to give 1 and 1/2 cc (ml) by mouth every 6 hours. This resulted in the infant being dispensed seven times the prescribed dose. This infant's mother is a nurse and caught the error; the infant never received any of the medication.
- # **Case 2:** A patient being treated for a craniotomy picked up her refill prescription of Hydrocodone/APAP 5mg/500mg (a medication for pain). She spelled out her name for the clerk/technician, who retrieved a prescription. The patient signed and paid for the medication and left the pharmacy. Later that evening the patient took her regular dosage (two pills) of medication, and became nauseated, lethargic, and started to vomit. She then discovered she had received another person's prescription, she received Lexapro 10mg (an antidepressant).
-

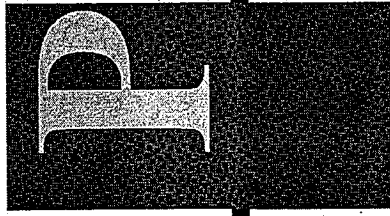
# P

## RESCRIPTION ERROR CASES

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### \$500 Fine

- # **Case 3:** A patient picked up his prescription for Citalopram 40mg. After taking the medication for several days, (four doses total) suffered several incidents of dizziness. The patient noticed the pills looked different and returned to the pharmacy where the pharmacist informed him he had been taking Norvasc 5mg (a low blood pressure medication). The patient recovered without Permanent harm.
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# PRESCRIPTION ERROR CASES

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## \$1,000 Fine

# **Case 1:** An adult female refilled her Norvasc (5mg once daily) prescription (a drug to lower blood pressure). The pharmacist incorrectly dispensed Lipitor (a drug to lower cholesterol). Five days later the patient suffered a stroke and was hospitalized. After 6 days in the hospital and six major procedures, she was released. One of her discharge medications was Lisinopril 10mg, which the pharmacist incorrectly filled with Lisinopril 20mg. The patient received the corrected medications and her condition stabilized.

# **Case 2:** An adult female refilled his prescription for Disopyramide 100mg. The pharmacist incorrectly filled with Desipramine 100mg. Within about 5 days the patient began to experience numerous symptoms, difficulty breathing; fainting spells; irregular or fast, pounding heartbeat; stomach pain; unusual weakness or tiredness; anxiety; constipation, or diarrhea; drowsiness or dizziness; and dry mouth, all side effects of Desipramine. The patient contacted the pharmacy and the PIC, stated the tablets were a generic replacement and the symptoms could not be related to the generic drug.

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# P

## PRESCRIPTION ERROR CASES

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### \$1,000 Fine

**# Case 3:** A 53-year-old female patient with diabetes was prescribed Avandia 4mg and Prevacid 30mg. The pharmacist incorrectly filled with Coumadin 4mg and Pravachol 40mg. The patient developed blurred vision and bruising and then went to urgent care. Her blood tests showed a markedly elevated clotting test (INR @ 6.3). She was seen by Ophthalmology and was diagnosed with a bleed (possibly a retinal bleed). She was treated and is better.

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# P

## RESCRIPTION ERROR CASES

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### \$2,500 Fine

# **Case 1:** A mature adult female was prescribed Climata 0.045-0.015mg Pro Patch. The pharmacist incorrectly dispensed Estradiol 0.0375mg patch. The patient took the incorrect medication for 7 months. The patient suffered a uterine build-up requiring a D&C medical procedure as a result of taking this medication.

# **Case 2:** A 58-year-old female patient was prescribed Prednisone 2.5mg tablets as 1 tablet bid (5mg/day). The pharmacist incorrectly dispensed Prednisone 50mg tablets as 1/2 tablet bid (50mg/day). As a result of this error the patient required hospitalization. The patient recovered without permanent harm.

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**P**

## **PRESCRIPTION ERROR CASES**

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### **\$4,200 Fine**

**# Case 1:** A 68-year-old female was receiving prescriptions from three doctors for enormous amounts of Soma and Tylenol with Codeine (both pain medications). In a nine-month period 4,696 doses were dispensed. The pharmacy dispensed all the prescriptions without contacting the prescribers. The patient died of cardiopulmonary arrest.

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ISMP

# Medication Safety Alert!®

E-mail: [ismpinfo@ismp.org](mailto:ismpinfo@ismp.org)

Hotline: 1 800 FAIL SAF(E)

Community/Ambulatory Care Edition

Volume 7, Issue 8 ■ August 2008

Schools need

## *Safety Briefs*

### ■ ISMP list of name pairs with tall man letters.

ISMP extends sincere thanks to all who completed our recent survey on the use of tall man letters to differentiate products with look-alike names. Tall man letters are uppercase letters that are used within a drug name to highlight its primary dissimilarities with look-alike drug names. One of the primary reasons for conducting this survey was to use the findings to prepare an unofficial list of look-alike drug name pairs with suggested tall man letters to guide practitioners and healthcare organizations. This is not intended to replace drug name safety testing to prevent name similarities before marketing a product. Many respondents shared their thoughts about other drug name pairs that might benefit from using tall man letters that were not included in our survey. We reviewed each suggestion very carefully, placing emphasis on the potential for patient harm, the frequency of use for each medication, and the need to keep the list short enough to avoid diluting the effectiveness of tall man letters. To help promote standardization, ISMP suggests that the tall man lettering schemes provided by FDA and ISMP be followed consistently. For a fully alphabetized list, please visit:

[www.ismp.org/Tools/tallmanletters.pdf](http://www.ismp.org/Tools/tallmanletters.pdf)



# FDA and ISMP Lists of Look-Alike Drug Name Sets With Recommended Tall Man Letters

The sets of look-alike drug names in the Tables below have been modified using "tall man" letters to help draw attention to the dissimilarities in their names. Several studies have shown that highlighting sections of drug names using tall man (mixed case) letters can help distinguish similar drug names,<sup>1</sup> making them less prone to mix-ups.<sup>2-3</sup> ISMP, FDA, The Joint Commission, and other safety-conscious organizations have promoted the use of tall man letters as one means of reducing confusion between similar drug names.

**Table 1** provides a list of FDA-approved established drug name sets with recommended tall man letters, which were first identified during the FDA Name Differentiation Project ([www.fda.gov/CDER/Drug/MedErrors/nameDiff.htm](http://www.fda.gov/CDER/Drug/MedErrors/nameDiff.htm)).

**Table 2** provides a list of additional drug name sets with recommendations from ISMP regarding the use and placement of tall man letters. This is not an official list approved by FDA. It is intended for voluntary use by healthcare practitioners and drug information vendors. Any product label changes by manufacturers require FDA approval.

**Table 1. FDA-Approved List of Established Drug Names with Tall Man Letters**

aceto <b>HEX</b> AMIDE - aceta <b>ZOL</b> AMIDE	hydr <b>AL</b> AZINE - hydro <b>OXY</b> zine
bu <b>PRO</b> Pion - bus <b>PIR</b> one	medroxy <b>PROG</b> ESTERone methyl <b>PRED</b> NISolone methyl <b>TEST</b> OSTERone
chlorpro <b>MAZ</b> INE - chlorpro <b>PAM</b> IDE	
clomi <b>PHE</b> NE - clomi <b>PRAM</b> INE	
cyclo <b>SPOR</b> INE - cyclo <b>SER</b> INE	ni <b>CAR</b> dipine - <b>NIF</b> edipine
<b>DAUN</b> o <b>RU</b> bicin - <b>DOXO</b> rubicin	predni <b>SONE</b> - predniso <b>LONE</b>
dimenhy <b>DRIN</b> ATE - diphenhy <b>DRAM</b> INE	sulf <b>ADIAZ</b> INE - sulfi <b>SOXAZOLE</b>
<b>DOB</b> UTamine - <b>DOP</b> amine	<b>TOLAZ</b> amide - <b>TOLBUT</b> amide
glipi <b>ZIDE</b> - gly <b>BUR</b> IDE	vin <b>BLAS</b> tine - vin <b>CRIS</b> tine

References: 1) Filik R, Purdy K, Gale A, Gerrett D. Drug name confusion: evaluating the effectiveness of capital ("Tall Man") letters using eye movement data. *Social Science & Medicine* 2004;59(12):2597-2601. 2) Filik R, Purdy K, Gale A, Gerrett D. Labeling of medicines and patient safety: evaluating methods of reducing drug name confusion. *Human Factors* 2006;48(1):39-47. 3) Grasha A. Cognitive systems perspective on human performance in the pharmacy: implications for accuracy, effectiveness, and job satisfaction. Alexandria (VA): NACDS; 2000 Report No. 062100.

One of the difficulties with the use of tall man letters is the lack of scientific evidence regarding which name pairs would most benefit from this error-reduction strategy as well as which letters to present in uppercase. Until further evidence is available, ISMP suggests that the tall man lettering scheme provided in these Tables be followed to promote consistency.

**Table 2. ISMP List of Additional Drug Names with Tall Man Letters**

<b>ALPRAZ</b> olam - <b>LOR</b> azepam	metro <b>NIDA</b> ZOLE - met <b>FORM</b> IN
am <b>LODI</b> Pine - a <b>MIL</b> oride	morphine - <b>HYDRO</b> morphine
aza <b>CITI</b> Dine - aza <b>THIO</b> prine	Nex <b>IUM</b> * - Nex <b>AVAR</b> *
ce <b>FAZ</b> olin - ce <b>TRIAX</b> one	ni <b>MOD</b> ipine - <b>NIF</b> edipine
Cele <b>BREX</b> * - Cele <b>XA</b> *	Novo <b>LOG</b> * - Novo <b>LIN</b> *
chlorpro <b>MAZ</b> INE - chlordi <b>azePOXIDE</b>	<b>OX</b> carbapazine - car <b>BAM</b> azepine
<b>CIS</b> platin - <b>CARBO</b> platin	oxy <b>CODONE</b> - Oxy <b>CONTIN</b> *
clonaz <b>PAM</b> - clo <b>NID</b> ine	<b>PAR</b> oxetine - <b>FLU</b> oxetine
clonaz <b>PAM</b> - <b>LOR</b> azepam	<b>PENT</b> obarbital - <b>PHEN</b> obarbital
clo <b>NID</b> ine - Klon <b>oPIN</b> *	Pr <b>iLOSEC</b> * - <b>PRO</b> zac*
<b>DACTI</b> Normycin - <b>DAPTO</b> mycin	<b>QUE</b> tia <b>pine</b> - <b>OLAN</b> zapine
e <b>PHED</b> rine - <b>EPINEPH</b> rine	qui <b>NINE</b> - qui <b>NID</b> ine
fenta <b>NYL</b> - <b>SUF</b> entanil	ri <b>TUX</b> imab in <b>FLIX</b> imab
<b>FLU</b> oxetine - <b>DUL</b> oxetine	Sand <b>IMMUNE</b> * - Sando <b>STATIN</b> *
guan <b>FACINE</b> - gua <b>iFEN</b> esin	<b>SERO</b> quel* - <b>SINE</b> quan*
Huma <b>LOG</b> * - Huma <b>LIN</b> *	Solu- <b>MEDROL</b> * - Solu- <b>CORTEF</b> *
<b>HYDRO</b> codone - oxy <b>CODONE</b>	<b>SUMAT</b> riptan - sita <b>GLIP</b> tin
<b>IDA</b> rubicin - <b>DOXO</b> rubicin	ti <b>ZAN</b> idine - tia <b>GAB</b> ine
<b>INV</b> anz* - <b>AVIN</b> za*	tra <b>ZOD</b> one - tra <b>MAD</b> ol
La <b>MIC</b> tal* - La <b>MISIL</b> *	<b>TREN</b> tal - <b>TEG</b> retol*
lami <b>VUD</b> ine - lami <b>TRI</b> gine	Zy <b>PREXA</b> * - Zyr <b>TEC</b> *

\* Brand names always start with an uppercase letter. Some brand names incorporate tall man letters in initial characters and may not be readily recognized as brand names. An asterisk follows all brand names in Table 2.



### Delegates Approve Eight Resolutions

Delegates from the member boards of pharmacy adopted eight resolutions during the NABP 104<sup>th</sup> Annual Meeting. Adoption of these resolutions result in actions such as task forces created at the direction of NABP President Rich Palombo, RPh, and NABP and its member boards collaborating with government agencies, health care associations, and other stakeholders. The resolutions are as follows.

**Resolution No. 104-1-08**

**Title:** "Tall Man" Letter Utilization For Look-Alike Drug Names

**Action:** Passed

*Whereas*, medication dispensing errors continue to occur as a result of look-alike prescription drug product names; and

*Whereas*, the use of "TALL MAN" letters highlighting the dissimilar letters in look-alike drug name pairs has been shown to assist in reducing these types of dispensing errors;

*Therefore Be It Resolved* that NABP work with the United States Food and Drug Administration (FDA) and the United States Pharmacopeia (USP), or other standard setting organizations to propose a national standard for "TALL MAN" lettering for look-alike drug names; and

*Be It Further Resolved*

that NABP encourage manufacturers of drug products with look-alike names, as identified by FDA, USP, or other standard-setting organizations, to use "TALL MAN" lettering on applicable product labels and avoid the use of look-alike names; and

*Be It Further Resolved* that NABP encourage manufacturers of pharmacy data systems and software to recognize "TALL MAN" lettering standards within their systems.

**Resolution No. 104-2-08**

**Title:** Standardized Internship Registration  
**Action:** Passed

*Whereas*, there is an identified need to standardize when interns are recognized and licensed by the boards of pharmacy in order

to accumulate required internship hours while completing the experiential practice requirements noted in the Accreditation Council for Pharmacy Education (ACPE) *Accreditation Standards and Guidelines for the Professional Program in Pharmacy Leading to the Doctor of Pharmacy Degree*;

*Therefore Be It Resolved* that NABP encourage state boards of pharmacy to uniformly register pharmacy interns and for NABP to work with American Association of College of Pharmacy and ACPE to establish a uniform date within the professional pharmacy curriculum to begin internship registration.

**Resolution No. 104-3-08**

**Title:** Task Force On Uniform Prescription Labeling Requirements  
**Action:** Passed

*Whereas*, concerns have arisen regarding prescription drug label content and format as contributing factors to patient confusion and medication errors; and

*Whereas*, some prescription drugs are known by several proprietary names (ie, brand name, branded generic name) as well as their established, official, or generic name, and such drugs may be identified on a prescription drug label by multiple different names; and

Karen  
Abbe/Pharmacy/DCANotes  
09/02/2008 09:00 AM

To Virginia Herold/Pharmacy/DCANotes@DCANotes  
cc Anne Sodergren/Pharmacy/DCANotes@DCANotes  
bcc  
Subject AP: Group aims to limit prescription mix-ups



## GROUP AIMS TO LIMIT PRESCRIPTION MIX-UPS

Website warns about drugs with similar names

By Lauran Neergaard  
Associated Press  
September 2, 2008

WASHINGTON - Take the generic drug clonidine for high blood pressure? Double-check that you didn't leave the drugstore with Klonopin for seizures, or the gout medicine colchicine.

Mixing up drug names because they look or sound alike - like this trio - is among the most common types of medical mistakes, and it can be deadly. Now new efforts are aiming to stem the confusion, and make patients more aware of the risk.

Nearly 1,500 commonly used drugs have names so similar to at least one other medication that they have already caused mix-ups, says a major study by the US Pharmacopeia, which helps set drug standards and promote patient safety.

Last week the influential group opened a Web-based tool to let consumers and doctors easily check to see whether they are using or prescribing any of these error-prone drugs, and what they might confuse it with. Try to spell or pronounce a few on the site - [www.usp.org](http://www.usp.org) - and it's easy to see how mistakes can happen.

Due out later this fall is a more patient-oriented website, a partnership of the nonprofit Institute for Safe Medication Practices and online health service iGuard.org, that will send users e-mail alerts about drug-name confusion.

And the Food and Drug Administration, which rejects more than a third of proposed names for new drugs because they are too similar to old ones, is preparing a pilot program that would shift more responsibility to manufacturers to guard against name confusion. The goal is to spell out how to better test for potential mix-ups before companies seek approval to sell their products.

"There are so many new drugs approved each year, this problem can only get worse," USP vice president Diane Cousins said.

At least 1.5 million Americans are estimated to be harmed each year from a variety of medication errors, and name mix-ups are blamed for a quarter of them.

Rarely does a company change a drug's name after it hits the market, although it has happened twice since 2005. The Alzheimer's drug Reminyl now is named Razadyne, after mix-ups, including two reported deaths, with the old diabetes drug Amaryl. The cholesterol pill Omacor is now named Lovaza, after mix-ups with blood-clotting Amicar.

Doctors' notoriously bad handwriting is not the only culprit. A hurried pharmacist faced with alphabetized bottles on a shelf might grab the wrong one.

Nor are computerized prescriptions a panacea. A doctor who e-prescribes still can click the wrong row on the alphabetized screen, picking the bone drug Actonel instead of the diabetes drug Actos.

Phone or fax a prescription, and static or smudged ink can turn the epilepsy drug Lamictal into the antifungal pill Lamisil.

Harder to measure but perhaps more common: A doctor means to prescribe a new drug but spells out a similar-sounding old one out of habit. Or the patient misspells or mispronounces a drug, and a health worker assumes it's the schizophrenia drug Zyprexa, not the antihistamine Zyrtec.

"We've had cases where a healthcare professional repeats what they think the patient's on, and the patient thinks they must know what they're talking about and agrees," Cousins said.

Enter the new Web tool. Cousins tells consumers to check it against their current medications, so they know to pay more attention to confusing ones at refill time. Question the pharmacist if the tablets look different than last time, said pharmacist Marjorie Phillips, medication safety coordinator at MCGHealth, the Medical College of Georgia's health system. It might just be a new generic, or it might be the wrong drug, she said.

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# newsletter

National Association of Boards of Pharmacy®

September 2008 / Volume 37 Number 8

## Boards Investigate Regulating Pharmacies for Patient Care Outcomes to Ensure Quality

Twelve years ago, David Brushwood, RPh, JD, a professor at the University of Florida College of Pharmacy, advised that the state boards of pharmacy should adjust their policies to begin regulating pharmacies for patient care outcomes. Some in pharmacy regulation also recognized the importance of such an approach. Charles R. "Chuck" Young, RPh, CFE, during his tenure as executive director of the Massachusetts Board of Registration in Pharmacy from 1996 to 2006, initiated several efforts, including creating a board staff position that focused on continuous quality improvement (CQI), the first of its kind in the nation. Today, boards are refocusing on CQI programs and are working to improve or implement their own plans.

In the push for CQI programs in the community pharmacy setting, boards

are looking at methods to evaluate the success of these programs and, subsequently, to establish uniform standards to facilitate uniform success.

NABP and stakeholders from all areas of pharmacy practice and regulation emphasize the importance of looking for the root of "quality-related events" in pharmacy structure and process, or systems, and adjusting those systems as necessary to support CQI programs and prevent the recurrence of medication errors. A necessary part of the process involves measuring changes that actually result from the adjustments to pharmacy systems.

According to CQI reports, health care "outcomes" refer to "changes in a patient's health status that result from the provision of health care." They state, however, "[o]ther



important outcomes are disability, discomfort, and dissatisfaction," and, "[e]xamples in pharmacy of directly measured outcomes would be adverse drug reactions, patient dissatisfaction, and diminished quality of life. Proxy outcomes measures would include the rate of medication-related emergency room visits or blood pressure readings of hypertensive patients."

Brushwood emphasized that measuring such outcomes is the only way

(continued on page 138)



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## Regulating for Outcomes

(continued from page 137)

to reliably determine the relevance and success of system changes. "The importance of outcomes," he said in the August 1996 issue of the *NABP Newsletter*, "is that they can be linked to particular aspects of structure and process, which can be altered to produce improved outcomes. Correspondingly, the importance of structure and process is that they can be linked with outcomes." This cyclical approach is fundamental to effective change.

According to a 2004 article, "Framework for Pharmacy Services Quality Improvement – a Bridge to Cross the Quality Chasm. Part I. The Opportunity and the Tool," in the *Journal of Managed Care Pharmacy*, "[q]uality improvement in health care services in the United States will be made in incremental changes that rely on a structure-process-outcome model. . . . Incremental changes in structure and process will result in the desirable outcome of meeting customer needs for more effective drug therapy and disease management."

Based on this model, pharmacy CQI programs should include looking at the number of errors and, once systems have been modified to reduce the incidence of errors, checking to see if that reduction has actually occurred. Ensuring that appropriate changes are being implemented and leading to

a reduction in quality-related events should be part of inspecting pharmacies for CQI.

By 2001, the momentum was building steam, as noted in the article, "Regulating for Outcomes as a Systems Response to the Problem of Drug-Related Morbidity," in the *Journal of the American Pharmaceutical Association*. "Health care accreditation agencies are moving toward regulation for outcomes," the article states. "Such regulations would clarify pharmacy's role in support of safe and effective pharmacotherapy and would constitute a commitment to pharmaceutical care as public service. A widely adopted system of measuring and improving the quality of medication use and outcomes could eventually lead to quality benchmarks in the community pharmacy setting, which would more firmly establish the value of the pharmacist in pharmacotherapy."

Today, focusing on quality and regulating for outcomes in patient care are consistent with the recommendations of the NABP 2007-2008 Task Force on Continuous Quality Improvement, Peer Review, and Inspecting for Patient Safety (CQI task force). This philosophy is an important aspect of the proposed pharmacy accreditation program that the CQI task force outlines.

To assist the boards with inspecting pharmacies to ensure that CQI practices are in place and operating successfully, the CQI task force recommends that NABP

explore the possibility of developing and implementing a pharmacy accreditation program, in conjunction with the boards, that will ensure pharmacies are operating in a manner consistent with CQI standards, decreasing the occurrence of quality-related events and ultimately increasing patient safety. With many boards facing budget strains and lacking the resources to increase the frequency and complexity of pharmacy inspections, NABP is currently exploring a community pharmacy accreditation program to address this need and to assist those boards in implementing or upholding pharmacy CQI standards in their jurisdictions.

NABP President Rich Palombo, RPh, remarked at the NABP 104<sup>th</sup> Annual Meeting in May 2008 that "the purpose and desire to develop such a program is to assist the boards and move patient safety forward. . . . Such a program will provide invaluable data to the boards about the pharmacies in their states and across the country." This information would provide useful evidence on which to base future systems and standards. "If we are successful in assisting pharmacists to effectively implement a meaningful definition of patient safety to their practices," President Palombo says, "we will have achieved something that is momentous and that will impact patient care and safety for generations."

To establish a foundation for pharmacy CQI program  
(continued on page 142)

nabp newsletter

## Regulating for Outcomes

(continued from page 138)

standards, the task force developed a form for use by each pharmacy in conducting a quality self-audit at least quarterly, as well as upon a change of pharmacist-in-charge. The goals of the quality self-audit are to monitor changes in the number of quality-related events over time, as well as to evaluate compliance with CQI procedures, and to develop a plan for improved adherence with the CQI program. This mechanism for measuring outcomes provides pharmacies with a quantifiable means of

assessing, initially, whether system adjustments are needed, and subsequently, whether they have improved patient care outcomes.

The task force used as a basis for its recommendations several aspects of CQI programs established over the past decade by the Massachusetts Board of Registration in Pharmacy. As mentioned earlier, the Board, under the direction of Young, who served as an ex officio member of the task force, initiated several efforts, including the establishment of the "continuous quality improvement coordinator" position. The coordinator position was created to review on-site CQI procedures

established by licensed pharmacies based on "Best Practice Recommendations" implemented by the Board. These efforts assisted the Board in moving forward in its attempt to proactively regulate for outcomes and move away from a reactive, strict disciplinary approach to regulation.

The cyclical approach to outcomes assessment, systems modification, and subsequent outcomes assessment follows the basic philosophy of evidence-based medicine, which has become increasingly pertinent in medical practice. The objective is to make patient care decisions, both on an

individual patient and a pharmacy systems level, based on past experience with and documentation of those systems that have proven successful. Once this assessment process begins and data is collected from multiple pharmacies, the boards may glean information on the most effective systems that lead to the best patient care outcomes, and they may anticipate problems based on previous poor outcomes.

The accumulation of such data will allow the boards to develop and implement uniform quality standards to improve outcomes nationally and, ultimately, enhance patient safety. ⑧

.....



**California State Board of Pharmacy**

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STATE AND CONSUMERS AFFAIRS AGENCY  
DEPARTMENT OF CONSUMER AFFAIRS  
ARNOLD SCHWARZENEGGER, GOVERNOR

**Date: September 27, 2008**

**To: Communication and Public Education Committee**

**Subject: Conscience Clauses**

---

Since the last board meeting, staff has been advised about a notice for comments on a proposed rule of the federal Department of Health and Human Services for providers to exercise moral or religious convictions that may prevent them from performing certain health care functions. Whereas the proposed rule deals principally to prohibit certain entities from requiring any person "to perform or assist in the performance of any part of a health service program or research activity funded by the Department [of Health and Human Services] if such service or activity would be contrary to his religious beliefs or moral convictions." Comments on the proposed regulation were due by September 25.

Since California has a law that ensures a provider's right to exercise conscience convictions provided patient care could still be provided, the board submitted comments to this effect.

Attached is the letter President Schell submitted in response to this proposed rulemaking of the federal government.



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STATE AND CONSUMERS AFFAIRS AGENCY  
DEPARTMENT OF CONSUMER AFFAIRS  
ARNOLD SCHWARZENEGGER, GOVERNOR

September 25, 2008

Office of Public Health and Science  
Department of Health and Human Services  
Attention: Brenda Destro  
Hubert H. Humphrey Building  
200 Independence Avenue, SW, Room 728E  
Washington DC 20201

**RE: COMMENTS OF THE CALIFORNIA STATE BOARD OF PHARMACY**  
**45 CFR Part 88: *Provider Conscience Regulation***

To Whom It May Concern:

I write on behalf of the California State Board of Pharmacy. We are pleased to have this opportunity to respond to a request for comments regarding a health care provider's ability to decline to provide patient care based on the provider's conscience and/or religious beliefs.

The California State Board of Pharmacy regulates 105,000 pharmacists, pharmacies and other individuals and businesses that ship, store and dispense prescription medicine into, throughout and from California. The board's mandate is consumer protection.

For several years, California has had statutory requirements (California Business and Professions Code section 733(b)(3)) that provide dispensing practitioners (which principally means pharmacists) with both the ability to practice their profession while preserving their ability to refuse from dispensing prescription drugs and devices that may be in conflict with their religious or moral beliefs, provided that:

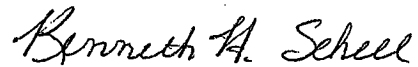
- (1) the practitioner advises his or her employer, in writing, listing the drugs or class of drugs to which the practitioner has an objection to dispensing at a time prior to the event, and
- (2) the employer can make a reasonable accommodation to the practitioner by establishing protocols that ensure that affected patients will have timely access to the prescription drug and/or device legally prescribed to them which are required to facilitate management of their condition.

Additionally, in the case of prescription drugs, the Board of Pharmacy believes that patients should be informed of their rights to obtain lawfully prescribed prescription drugs and devices. California law required that the board develop a Notice to Consumers, that could be either posted in a pharmacy or printed on the back of customer receipts, to ensure patients are advised of their rights to lawfully prescribed medicine. A reduced-size copy of the poster that carries this notice is enclosed with this letter.

The board wishes only to comment and encourage that where the ability of an individual practitioner is granted to exercise his or her personal beliefs with respect to provider conscience rights, that there is also a duty to ensure the provision of care to the patient. Insofar as any health care practitioner may exercise conscience rights, there needs to be a process to ensure that patients may receive uninterrupted care that has been lawfully prescribed by other providers.

Thank you for this opportunity to provide comments on this important health care issue.

Sincerely,

A handwritten signature in black ink, reading "Kenneth A. Schell". The signature is written in a cursive style with a large initial 'K' and 'S'.

Kenneth Schell  
President

Encl

NOTICE  
TO CONSUMERS

# KNOW YOUR RIGHTS

UNDER CALIFORNIA LAW CONCERNING MEDICINE  
AND DEVICES PRESCRIBED TO YOU

**YOU HAVE THE RIGHT TO RECEIVE  
MEDICINE AND DEVICES LEGALLY  
PRESCRIBED TO YOU, UNLESS:**

- 1** The medicine or device is not in stock in the pharmacy.
- 2** The pharmacist, based upon his or her professional judgment determines providing the item:

*Is against the law, could cause a harmful drug interaction or could have a harmful effect on your health.*



This pharmacist may decline to fill your prescription for ethical, moral or religious reasons, but the pharmacy is required to help you get the prescription filled at this or another nearby pharmacy timely. The pharmacy may decline to provide the medicine or device if it is not covered by your insurance or if you are unable to pay for the item or any copayment you owe.

**If the pharmacy is unable to fill your prescription, you are entitled to have the prescription returned to you or transferred to another nearby pharmacy. Ask about our procedure to help you get an item that we don't have in stock.**

**ANY QUESTIONS? ASK THE PHARMACIST!**



CALIFORNIA STATE BOARD OF PHARMACY  
1001 L Street, Suite 1000  
Sacramento, CA 95811  
(916) 445-2500 • www.sbp.org

**BE AWARE & TAKE CARE: Talk to your pharmacist!**





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STATE AND CONSUMERS AFFAIRS AGENCY  
DEPARTMENT OF CONSUMER AFFAIRS  
ARNOLD SCHWARZENEGGER, GOVERNOR

**Date: September 26, 2008**

**To: Communication and Public Education Committee**

**Subject: Update on Consumer/Patient Surveys undertaken for SB 472 Medication Label Redesign Project**

---

Senate Bill 472 (Chapter 470, Statutes of 2007) added Section 4076.5 to the Business and Professions Code, relating to development of patient-centered prescription drug labels. This statute requires the board to promulgate regulations for standardized, patient-centered, prescription drug labels on all prescription medication dispensed to patients in California by January 2, 2011. The board is also directed to hold special public forums statewide in order to seek input from the public on the issue of prescription labels.

The first special public forum was held at a community center in Fremont on April 12, 2008. Approximately 40 people attended, though most attendees were from the pharmaceutical industry. Three attendees at the initial forum were "public" participants, so it became apparent that the board would need to find alternative venues to increase participation from consumers.

In May 2008, board staff developed a prescription label survey for distribution at public outreach events. The survey is available in English and Spanish. It is designed to elicit information from the public about prescription labels using the following questions:

1. What information on the label is most important to you?
2. Do you understand the directions on the prescription label?
3. What would you change on the prescription label?
4. What would make the prescription label easier to read?
5. Other suggestions?

Since late May, board staff have been using the survey to interview attendees at public events. Consumers have been invited to complete surveys on-site during the events, or mail them to the board using the self-addressed envelopes provided. This method of soliciting information has proved less intimidating to consumers than individually speaking at public hearings. Board staff attending the community events have also reported positive feedback when discussing this initiative with the public.

The survey can also be completed and submitted electronically on the board's Web site at [https://app.dca.ca.gov/pharmacy/survey\\_sb472.asp](https://app.dca.ca.gov/pharmacy/survey_sb472.asp). In addition, AARP has invited consumers to "Put in Your Two Cents on Prescription Labeling" in the AARP September 2008 newsletter. A copy of AARP's article is attached, and available at: [http://www.aarp.org/states/ca/articles/Put in Your Two Cents on Prescription Labeling.html](http://www.aarp.org/states/ca/articles/Put_in_Your_Two_Cents_on_Prescription_Labeling.html).

The board has also provided consumers with one-page fact sheets entitled, "Do you understand the directions on your Rx medicine label?" The fact sheet provides background information related to SB 472, and printed samples of faux prescription labels as a visual aid.

A total of 175 consumers have completed surveys thus far. Attached are charts reflecting responses to each survey question. Not every consumer provided an answer to each question, while others provided multiple answers to individual questions. Many consumers gave the same response (i.e., larger font) to more than one question.

Trends have been identified in the answers provided thus far. Many responses suggest that the purpose of the drug be printed on the prescription label, and that a larger or bolder type font be used.

When asked what would make prescription labels easier to read, the top two responses were:

- Larger or bolder print  
(64 of 109 responses = 58.7%)
- Highlighting directions for use and other information in colors other than black  
(15 of 109 responses = 13.8%)

When asked what to change on the prescription label, the top two responses were:

- Print should be larger or darker  
(50 of 144 responses = 34.7%)
- Include purpose of the drug – state what condition the medication is intended to treat  
(26 of 144 responses = 18.1%)

When asked what information on the label was most important, the top two responses were:

- Directions for use  
(55 of 265 responses = 20.8%)
- Dosage prescribed  
(41 of 265 responses = 15.5%)

When asked for other suggestions, the top two responses were:

- Easy-open lids should be used; no child-proof caps for seniors  
(7 of 50 responses = 14%)
- Include purpose of the drug – state what condition the medication is intended to treat  
(6 of 50 responses = 12%)

Board staff will provide another update on the status of survey responses at the next SB 472 Medication Label Subcommittee meeting. In addition, the board will capitalize on the department-sponsored Professionals Achieving Consumer Trust Summit scheduled for November 2008 as an ideal opportunity to engage other professions in the development of a patient-centered prescription label.





## Put in Your Two Cents on Prescription Labeling

By: State: California | Source: aarp.org

The California State Board of Pharmacy is seeking public input to make prescription labels easier to understand. Recent studies show that 46 percent of patients misunderstand the prescription label that they get from the pharmacy. Mistakes based on misread labels harm at least 1.5 million people every year and costs about \$1 billion dollars annually.

"With few exceptions, most prescription container labels are not terribly user friendly," said Board Executive Officer Virginia Herold. "Yet it's crucial for patients to understand the information on them for the prescriptions to be effective."

Improved labels will aid patients in taking their medicine as prescribed.

Over the next several months, the Board will hold public meetings to elicit suggestions from consumers and health care providers to improve prescription labels and make them easier to understand.

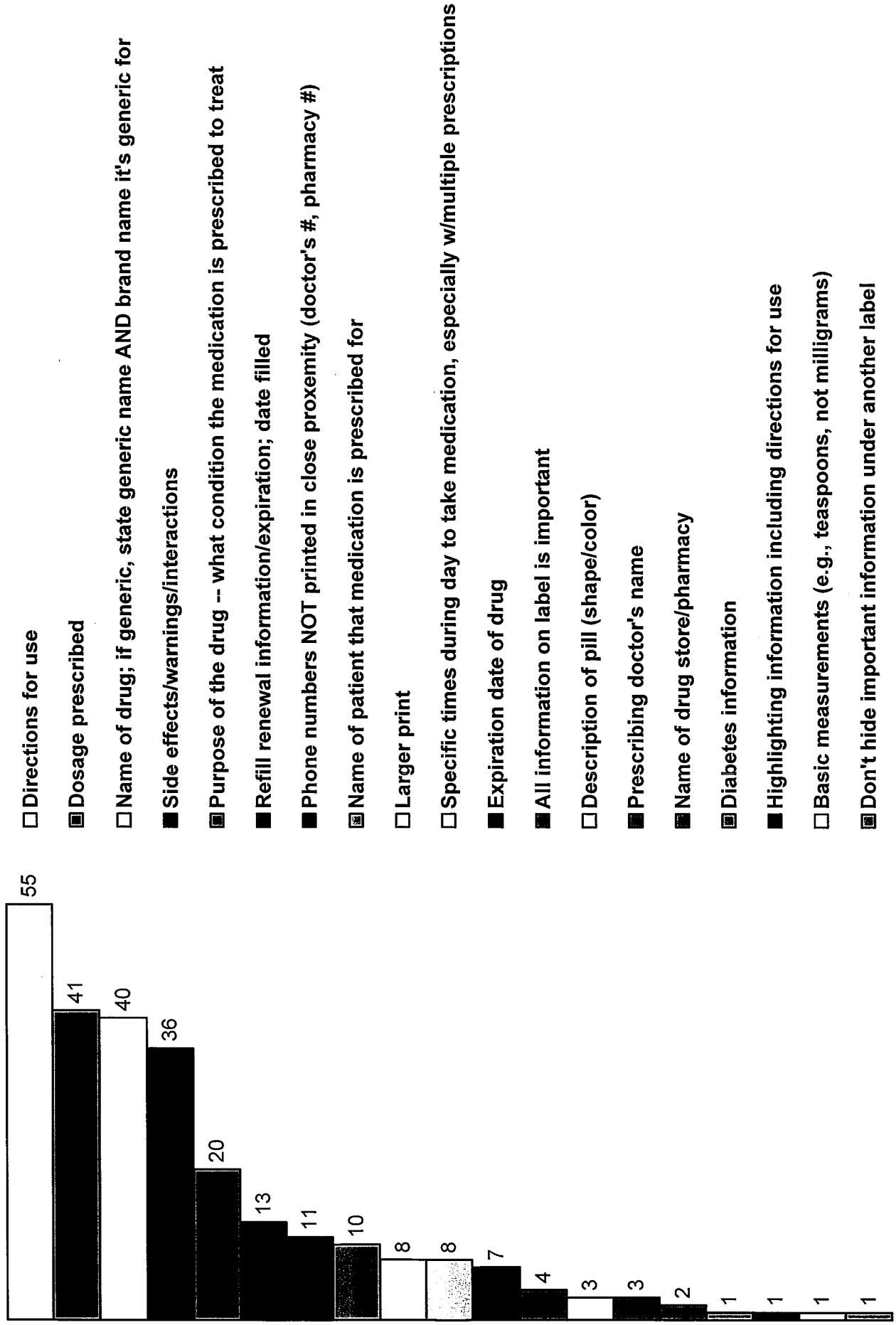
In addition, a survey has been placed on the Board of Pharmacy website to allow consumers the opportunity to provide input on such changes. Please visit [www.pharmacy.ca.gov](http://www.pharmacy.ca.gov) and click on the "What's New" section under "Quick Hits" for the Prescription Label Survey.

The information collected from patients will be used by the Board to develop new regulations as required by the California Patient Medication Safety Act of 2007.

### Related Articles

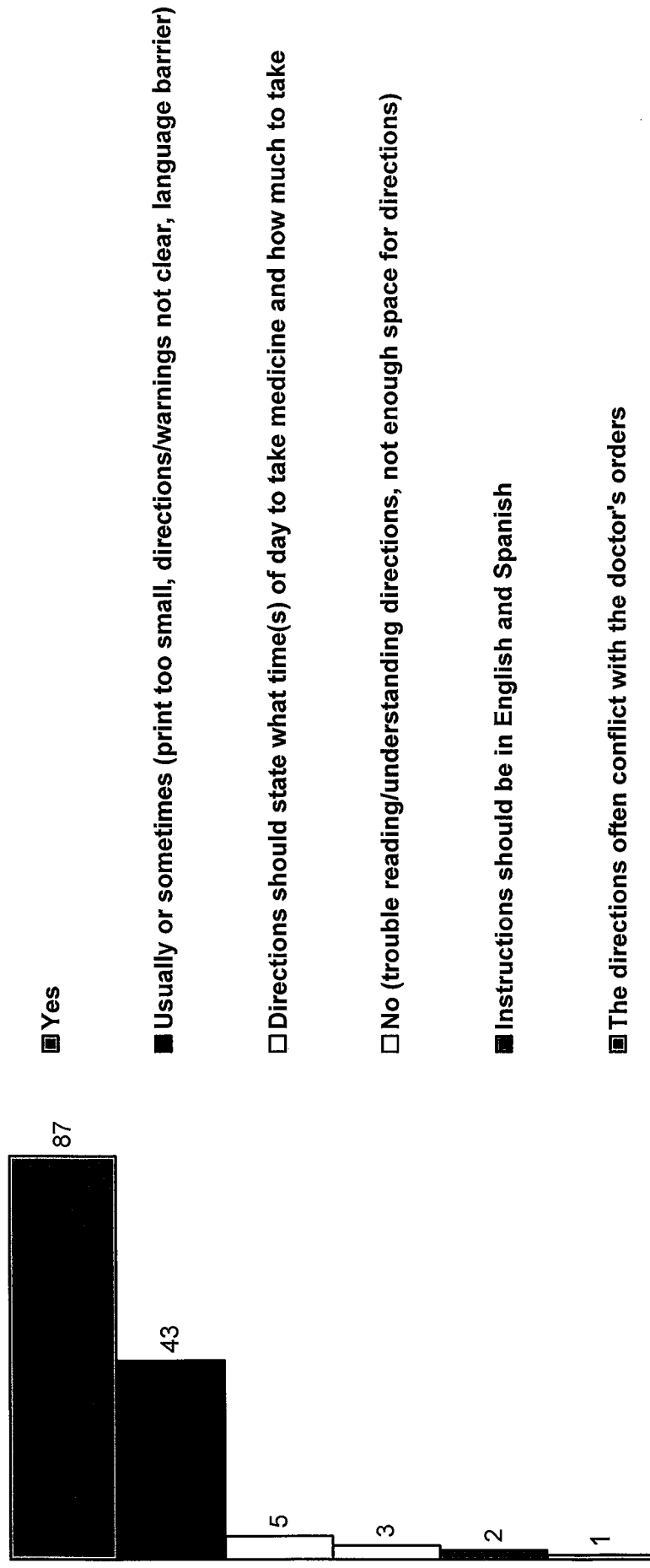
[Ask Your Doctor About these Possible Rx Alternatives](#)

# **QUESTION #1: What information on the label is most important to you?** 265 responses to Question #1 as of 9/26/08



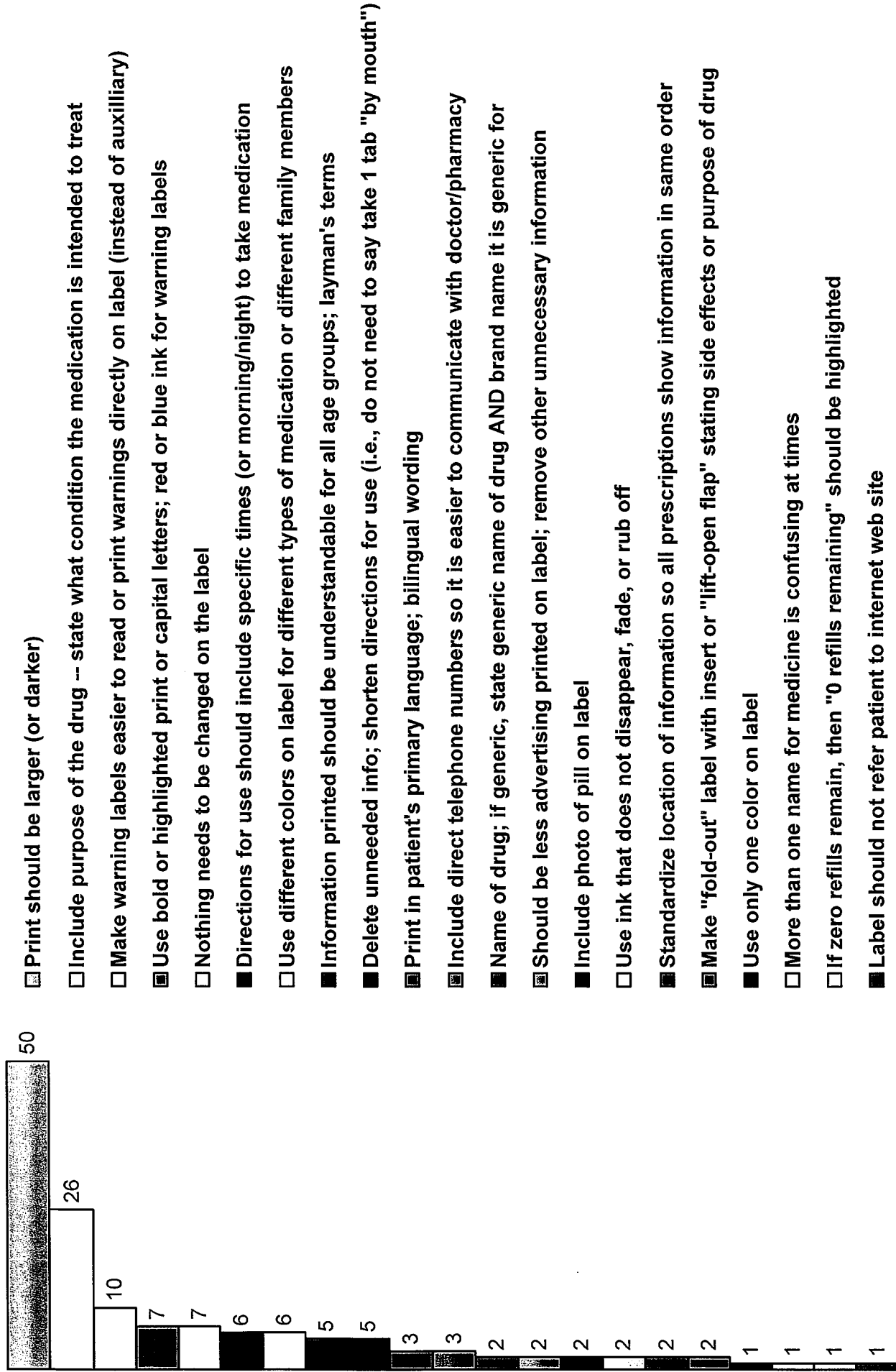
## QUESTION #2: Do you understand the directions on the prescription label?

141 responses to Question #2 as of 9/26/08



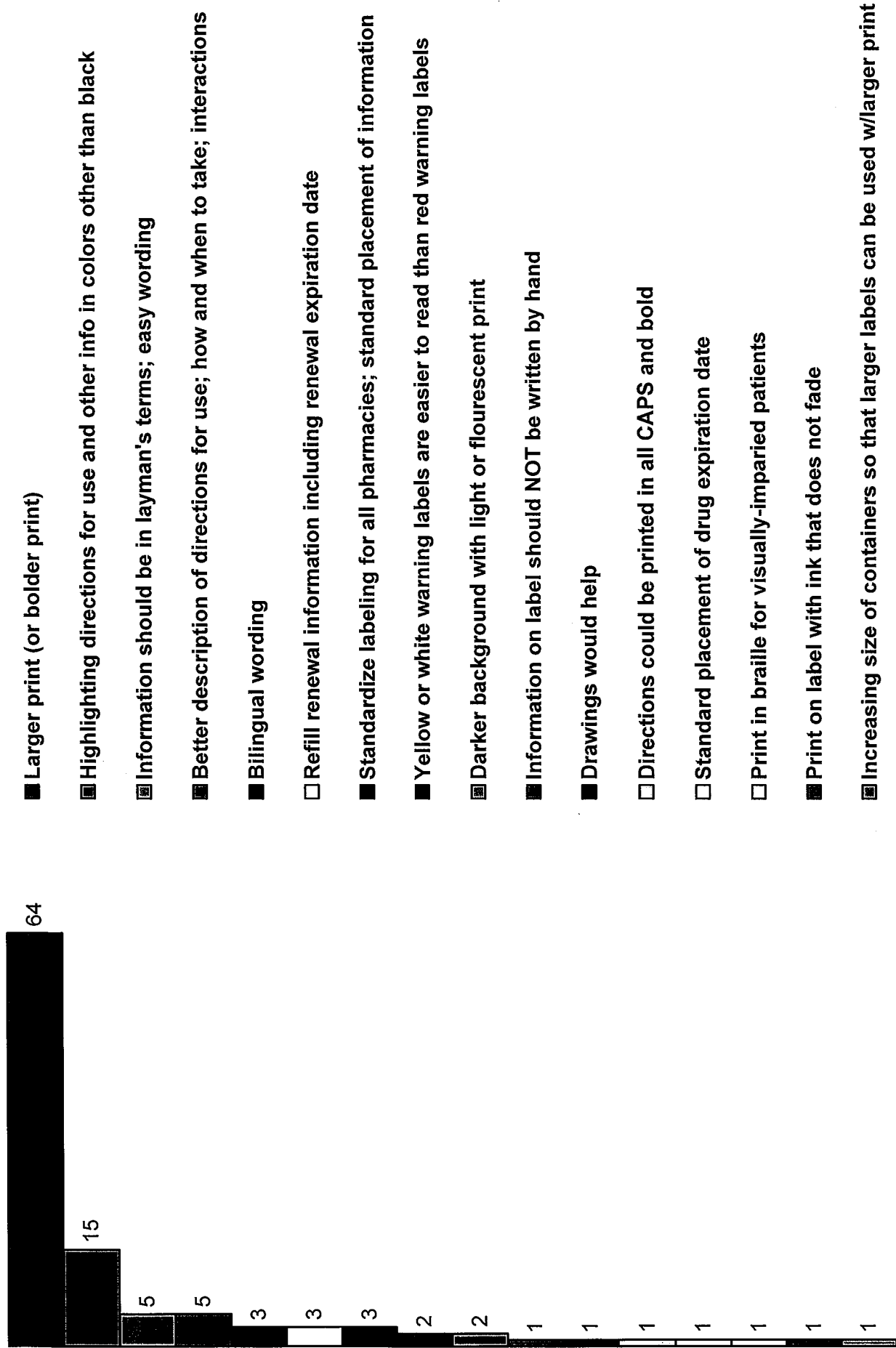
### QUESTION #3: What would you change on the prescription label?

144 responses to Question #3 as 9/26/08



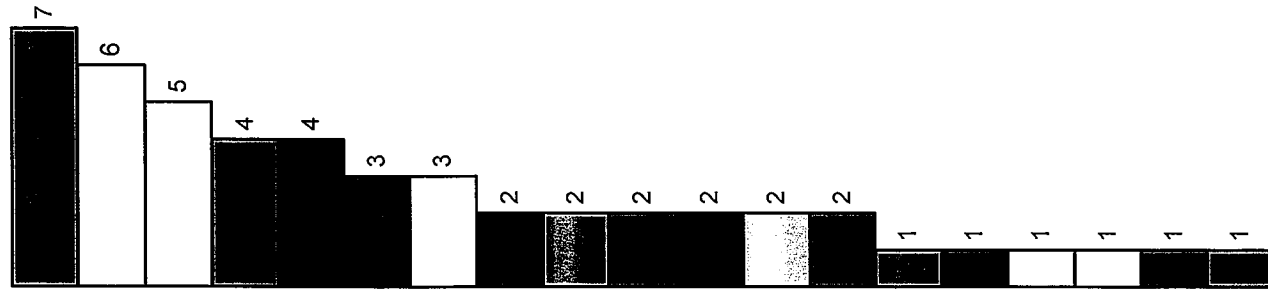
# QUESTION #4: What would make the prescription label easier to read?

109 responses to Question #4 as of 9/26/08



## QUESTION #5: Other suggestions?

50 responses to Question #5 as of 9/26/08



- ☒ Easy-open lids should be used; no child-proof caps for seniors
- ☐ Include purpose of the drug -- state what condition the medication is intended to treat
- ☐ Use different color for printing directions for use or pharmacy telephone number
- ☒ Make directions for use simple, clear, understandable; print in primary language of patient
- ☒ Standardize location of information so all prescriptions show information in same order
- ☒ Different colored bottles or caps would help identify medications
- ☐ Bigger font for drug expiration date; bigger font for directions for use
- ☒ Make label easier to remove completely (for privacy/security) when discarding container
- ☒ Bottles should be in travel/airplane size; large bottles are clumsy and take up space
- ☒ Side effects should be stated
- ☒ Have all bottles rectangular shape w/flat surface and directions printed on long side
- ☐ Use top of lid for info; containers opening at bottom leave room for larger label
- ☒ Don't cover prescription number with warning labels; use colored symbols as warnings
- ☒ Labels should be waterproof
- ☒ Don't allow label to completely cover bottle; leave space to see medication remains
- ☐ Advise patient when color of drug changes, so it won't be perceived as medication error
- ☐ Include a "plan" for all prescriptions (i.e., Calcium supplements can't be taken with...)
- ☒ Put picture of pill on label
- ☒ Note changes in size, color, and shape of pills



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STATE AND CONSUMERS AFFAIRS AGENCY  
DEPARTMENT OF CONSUMER AFFAIRS  
ARNOLD SCHWARZENEGGER, GOVERNOR

**Date: September 25, 2008**

**To: Communication and Public Education Committee**

**Subject: Update and Discussion Regarding the Consumer Fact Sheet Series with the California Schools of Pharmacy Interns**

---

Several years ago, the board approved a proposal by the committee to integrate pharmacy students into public outreach activities. The intent was to offer students the opportunity to work with the board on meaningful projects promoting consumer education, while the board would benefit from the production of the materials. Initially the project was initiated with UCSF.

At the October 2007 Board Meeting, the board accepted the committee's recommendation to invigorate this program by offering other schools of pharmacy the opportunity to have their students develop one-page fact sheets on various topics, and then have the developed fact sheets reviewed by an expert. Representatives from other California pharmacy schools were very interested in this project for their students.

At that time, the board directed staff to proceed with the committee's recommendation for development of a template for future fact sheets, and work the schools of pharmacy to initiate this intern project.

Following is a letter sent to the schools of pharmacy inviting pharmacist interns the opportunity to produce public information fact sheets on items of public health interest. The board has not received any formal notification from the schools designating a faculty member to serve as liaisons, but interest in this appears high.



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STATE AND CONSUMERS AFFAIRS AGENCY  
DEPARTMENT OF CONSUMER AFFAIRS  
ARNOLD SCHWARZENEGGER, GOVERNOR

September 11, 2008

Dean David Hawkins, PharmD  
California Northstate College of Pharmacy  
10811 International Drive  
Rancho Cordova, CA 95670

Dear Dean Hawkins:

The Board of Pharmacy is interested in offering all pharmacist interns, regardless of their academic year, the opportunity to work on a joint project with the board to produce public information fact sheets on items of public health interest. Once developed, the one-page fact sheets will be published and distributed by the board from its office and Web site and at community outreach events.

The fact sheets are intended to provide a quick summary about a timely health issue. Fact sheets may include questions to "Ask a pharmacist" about, so that consumers can make informed decisions about their health care medication use. The fact sheets will benefit the public by educating them about the topic and encouraging discussions with pharmacists as health care providers. The students will gain experience by researching a health care topic and producing salient public information at a basic reading level, in a limited space.

Each fact sheet should contain:

- General information on the topic;
- Facts or in some cases, common misunderstandings/myths about the topic;
- Questions consumers can discuss with their pharmacists about the topic; and
- Footnotes documenting origin of the information referenced on the fact sheet (this information will be checked by the Board).

Copies of fact sheets developed by UCSF's interns and the Center for Consumer Self Care are enclosed and may serve as templates.

The role of your school's faculty in this project involves advising interns about this project and providing them with information about how to contact the appropriate project leader at the Board. The faculty may be asked by the board to provide subject matter assistance and to review the fact sheets prior to submission to the board.

After a fact sheet is submitted, its contents will be reviewed by the board's legal advisors and others. The completed and subsequently selected fact sheet then will be formatted and published, and the board will send a letter to the student and supervising faculty member, acknowledging the student's contribution. Additionally, once each year, the board will host a



Dean David Hawkins  
September 11, 2008  
Page 2

competition to acknowledge the best fact sheet developed during the prior year. The winner will be announced and recognized at a board meeting.

The board strongly supports the expansion of this project to all California schools of pharmacy. We believe that an intern's ability to research and distill key health care information about a topic, and present it in a consumer-friendly format, will benefit interns in their future career and help educate the public concerning their health care.

Thank you for your consideration and future participation. Should you have questions, please do not hesitate to contact me at (916) 574-7911.

I look forward to hearing from the designated faculty member you assign to this project.

Sincerely,

Virginia Herold  
Executive Officer

encl



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STATE AND CONSUMERS AFFAIRS AGENCY  
DEPARTMENT OF CONSUMER AFFAIRS  
ARNOLD SCHWARZENEGGER, GOVERNOR

**Date: September 26, 2008**

**To: Communication and Public Education Committee**

**Subject: Development of New Consumer Brochures by the Board**

---

At the September 2007 Committee meeting, the committee approved the content of several fact sheets. The committee recommended that all board brochures have a generally consistent format and appearance, including the use of the board's logo and slogan (Be Aware and Take Care: Talk to your Pharmacist.)

Board staff made all formatting changes, as well as incorporated changes suggested at subsequent committee meetings to the following fact sheets:

- Traveling Medicine Chest
- Pill Splitting – Not for every person, and not for every pill
- Vaccinations and Travel Outside the U.S.

Earlier this month board staff routed these fact sheets to the department for review and approval. (This is required before the board can disseminate these fact sheets or post them on our Web site.) Minor edits were recommended by the department and will be incorporated prior to posting on the Web site.



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STATE AND CONSUMERS AFFAIRS AGENCY  
DEPARTMENT OF CONSUMER AFFAIRS  
ARNOLD SCHWARZENEGGER, GOVERNOR

**Date: September 25, 2008**

**To: Communication and Public Education Committee**

**Subject: Request from PPSI to Develop Consumer Brochures**

---

Following is a request from Fred S. Mayer, RPh, MPH, with PPSI requesting that the board give consideration to developing a consumer brochure on patient adherence and compliance.

Included with his request are several statistics that highlight the potential benefit to such a fact sheet.

Also provided is a list of topics previously considered by the committee. Mr. Mayer's suggested brochure, while related to some of the topics, is not explicitly listed. Should the committee so choose, it may be an opportune time to review this list and make any additions.



PPSI <ppsi@aol.com>  
07/21/2008 10:52 AM

To virginia\_herold@dca.ca.gov, kenneth.h.schell@sharp.com,  
glopow@aol.com  
cc  
bcc  
Subject Development of New Consumer Brochure on Adherence and  
Compliance of Medications, July 23-24, 2008 California BOP  
Consumer Affairs Hearing

July 21, 2008

Virginia Herold  
Chief Executive Officer  
California Board of Pharmacy  
1625 N. Market Blvd, N219  
Sacramento, CA 95834

Re: Board of Pharmacy Public Meeting, July 23-24, 2008  
4:05 p.m. - 5:15 p.m., July 23, 2008, Agenda Item 3, Development of New Consumer  
Brochures

Dear Ginny:

PPSI, a 501 C (3) nonprofit public health, consumer, pharmacy education organization, would like to bring up for discussion at the Communication and Public Education Committee meeting of the California Board of Pharmacy under Agenda Item 3, Development of New Consumer Brochures, the following items:

1. A new brochure on patient adherence and compliance to be put together by the California State Board of Pharmacy and the UCSF Center for Consumer Self Care
2. Failure to comply with patients and consumers' medication regime resulting in over 30% of Rx's issued by physicians never being filled at a pharmacy resulting in great hardship.
3. Failure of non compliance to taking medications which are maintenance prescriptions, increases costs to patients and consumers by \$163 billion in the USA.
4. Failure for patients who are on maintenance Rx's especially blood pressure and hypertension meds resulting patients having strokes and other costly illnesses in the USA.
5. Over 50% of medications which are prescribed as maintenance meds and should be taken for at least six months or a year to have results are discontinued before six months or more result in great harm and increased costs.

6. Over 107,000 patients die each year from adverse drug events, mixing Rx's with OTCs, herbals and dietary supplements along with prescription medications according to Lucien Leape, M.D. Harvard School of Medicine.

7. This figure of 107,000 also accounts for non compliance and adherence to medication regimes.

I would great appreciate any consideration the California Board of Pharmacy and the UCSF Center for Consumer Self Care gives to consider the "Ask Your Pharmacist" series to put together a consumer hand out brochure on this very most important public health issue.

Unfortunately I will be unable to attend the July 23rd meeting in Newport Beach, California. PPSI is a nonprofit without travel funding expenses.

Thank you for your assistance.

Fred S. Mayer, RPh, MPH  
President, PPSI  
101 Lucas Valley Road, Suite 384  
San Rafael, CA 94903  
Telephone: 415 479-8628  
Fax: 415 479-8608  
Email: [ppsi@aol.com](mailto:ppsi@aol.com)  
Website: [www.ppsinc.org](http://www.ppsinc.org)

The Famous, the Infamous, the Lame - in your browser. [Get the TMZ Toolbar Now!](#)

## Topics Suggested for Consumer Fact Sheet Series

1. Different dosage form of drugs -- the ability for patients to request a specific type of product (liquid or capsule) that would best fit the patients' needs for a given type of medication. Also differences between tablespoons, mLs, cc, teaspoon measures.
2. Falls - with emphasis on medicines that put you at risk - talk to your pharmacist/read the label
3. Consumer reporting of adverse drug events -- based on FDA quote "Consumers can play an important public health role by reporting to FDA any adverse reactions or other problems with products the Agency regulates. When problems with FDA-regulated products occur, the Agency wants to know about them and has several ways for the public to make reports. Timely reporting by consumers, health professionals, and FDA-regulated companies allows the Agency to take prompt action. FDA evaluates the reports to determine how serious the problem is, and if necessary, may request additional information from the person who filed the report before taking action. "
4. Driving when you are taking medicines
5. Rebound headaches and the danger of taking too many OTC pain relievers for headaches
6. Hormone replacement therapy -- what is the current thinking?
7. Pediatric issues
8. Poison control issues
9. Ask for drug product information and labels in your native language if you cannot read English
10. Cough and cold meds and addiction issues (specifically, dextromethorphan)
11. Taking your Medicines Right (four fact sheets)
  - How to Use an Rx Label
  - How to Use an OTC Label
  - How to Use a Dietary Supplement Label
  - How to Use a Food Label
12. Take Only as Directed (three fact sheets)
  - Dangers of Double Dosing
  - Disposal of Out of Date Medicines
  - Tips on How to Take your Medicine Safely
13. Ask your Pharmacist or Doctor
  - Have a question?
  - Ask your Pharmacist for Native Language Materials/Labeling
14. Questions to Ask About your Condition or Medicine:
  - Diabetes: Questions to Ask
  - Cardiovascular Disease: Questions to Ask
  - Asthma: Questions to Ask
  - Depression: Questions to Ask

- Arthritis and Pain: Questions to Ask
- 15. What Can I do to Prevent Disease?
  - Regular Check Ups
  - Screening
  - What Medicare Offers
- 16. Childhood Illnesses and Conditions
  - Head Lice
  - Fever Reducers: Questions to Ask
  - Immunizations: Questions to Ask & Schedules
- 17. Questions to Ask About Your Medicines
  - What Are Drug Interactions?
  - Ask Your Pharmacist: Medicare Part D Prescription Drug Benefit
  - Medication Therapy Management – What Is It?
  - Drinking and Taking Medicines
- 18. Learn More about your Medicine
  - Credible Sources on the Internet

### ***Medicine Safety***

- Heading: Read the Label
  - “How to Read an Rx Label”
  - “How to Use an OTC Label”
  - “How to Use a Dietary Supplement Label”
  - “How to Use a Food Label”
- “A Medicine Chest for Traveling”
- “Drug-Drug Interactions”

### ***Health Topics***

- “Diabetes and Aspirin”
- “Asthma – Safe Use of Inhalers”
- “Immunizations”
- “Checking Your Blood Pressure”
- “Head Lice – Back to School”

### ***Tips for Parents***

- read the label
- teaspoons and tablespoons
- more is not better
- ask your pharmacist

### ***Aspirin for Heart Attack and Stroke***

- aspirin is not for everyone
- risks associated with aspirin
- what to think about before starting daily aspirin

### ***Counterfeit Medicines***

- dangers of using counterfeit medicines
- what to look for
- ask your pharmacist

### ***Consumer Drug information on the Internet***

- how to judge reliable information
- sites to trust
- where to look
- ask your pharmacist

### ***Allergies to Medicines***

- what to look for
- what to do
- before purchase, read the label – inactive ingredient section
- consumer reports to FDA (MedWatch)
- ask your pharmacist

### ***Immunizations***

- immunization schedules
- what schools require
- awareness alert that some pharmacies provide immunization services
- ask your pharmacist





**California State Board of Pharmacy**

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STATE AND CONSUMERS AFFAIRS AGENCY  
DEPARTMENT OF CONSUMER AFFAIRS  
ARNOLD SCHWARZENEGGER, GOVERNOR

**Date: September 23, 2008**

**To: Communication and Public Education Committee**

**Subject: Update Report on *the Script***

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The next issue of *The Script* is scheduled for publication in January 2009 and will focus primarily on new laws and regulations enacted in 2009. Unfortunately, as a result of the Governor's Executive Order, the board lost its newsletter editor, Retired Annuitant Hope Tamraz. We are hopeful that this position will be restored in sufficient time to meet the January 2009 publication. Ms. Tamraz has agreed to volunteer to perform this work in the event her position is not restored.



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STATE AND CONSUMERS AFFAIRS AGENCY  
DEPARTMENT OF CONSUMER AFFAIRS  
ARNOLD SCHWARZENEGGER, GOVERNOR

**Date: September 25, 2008**

**To: Communication and Public Education Committee**

**Subject: Update on the Board's Public Outreach Activities**

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Public and licensee outreach activities performed during the first quarter of Fiscal Year 08/09 include:

July 2, 2008: Board Member Goldenberg provided information about pharmacy law to medical staff at the Jewish Home Hospital.

July 8, 2008: Board Inspector Orlandella represented the board on a panel to a group of seniors and provided general information and responded to questions in Roseville, CA.

July 9, 2008: Executive Officer Herold provided a presentation in San Diego to a group of 150 individuals and agencies regarding California law and drug take back programs in communities.

July 12, 2008: Board Inspector Sarah Bayley and Associate Analysts Durst and Abbe staffed a resource table at the Lotus Festival in Los Angeles. They distributed consumer brochures and interviewed attendees about their prescription labels as part of the board's initiative to implement a patient-centered prescription label.

August 17, 2008: Associate Analysts Durst and Abbe and Assistant Executive Officer Sodergren staffed the department's booth at the State Fair and distribute brochures, respond to public questions and elicit suggestions to improve the labeling on prescription labels.

August 25, 2008: Executive Officer Herold provided a presentation at a conference sponsored by the California Integrated Waste Management Board on the board's concerns with drug take back programs and sharps container returns.

September 17, 2008: Executive Officer Herold provided a presentation to Astra-Zeniga's government relations staff on SB 1307 (Ridley-Thomas).

September 18, 2008: Executive Officer Herold provided a presentation at the Generic Pharmaceutical Associations annual meeting on SB 1307 (Ridley-Thomas).

September 23, 2008: Executive Officer Herold participated in a web cast on California's pedigree requirements and SB 1307 (Ridley-Thomas) hosted by software provider SAP.

September 23, 2008: Board President Shell and Executive Officer Herold made a presentation at a national meeting held in Sacramento regarding California's pharmacy law and the requirements barring needles and syringes being inappropriately discarded in landfills and other locations.

#### Future Activities

Unfortunately consumer outreach events scheduled for the end of the year were cancelled because of budget constraints resulting from the Executive Order. Board staff will continue to identify future outreach events to attend once budget restrictions are lifted. Below are a few professional events that the board will be attending.

- President Schell will speak on requirements regarding conscience provisions in California law at Loma Linda University on October 8.
- A Board Inspector will provide a CE presentation to the Sacramento Valley Society of Health-Systems pharmacist in early November.
- Executive Officer Herold will participate in several forums as well as provide three presentations at Seminar 2008 in October, an event sponsored by the California Society of Health-Systems Pharmacists.
- Assistant Executive Officer Sodergren and Supervising Inspector Ratcliff will attend Seminar 2008 (October) and staff a booth to answer questions and respond to comments from attendees.
- Supervising Inspector Ratcliff will present information about pharmacy law and the board's pharmacy inspections at the South Bay Pharmacist Association in November.
- Supervising Inspector Ratcliff will present information about pharmacy law and the board's pharmacy inspections at a statewide meeting of California State University Pharmacists (January 2009)
- Executive Officer Herold will present a CE program at Outlook 2009 (February), an event sponsored by the California Pharmacists Association and The Pharmacy Foundation of California.